Aged & Disabled Waiver Provider
Conference Call Questions

February 18, 2014

1. Why can't policy be changed to allow LPN's to act as Case Managers since there is no skilled nursing required?

Answer: Case Management is primarily a social work position. The exception was made in policy to allow for a RN or counselor to do a social work type position.

2. Why does the Homemaker RN have to be present during the Service Planning meeting with the Case Manager?

Answer: The Service Plan is the key planning document for the member. It is the driving force and key element in the development of the Plan of Care. It is a requirement that the Homemaker RN be at the Service Planning meeting, it is not a requirement for the HM RN to be at the WVMI assessment.

3. When is Case Management going to get a rate increase?

Answer: There are no current plans to increase case management rates.

March 18, 2014

4. On the log review by the RN, can we accumulate minutes month to month to bill when we get 1 unit (15 minutes) or do the minutes need to be billed in the month that the logs were reviewed.

Answer: First we are assuming by "log" you mean the Plan of Care/worksheet. With this said, you need to bill it for the date it was reviewed. The Bureau for Medical Services is looking at possible changes in the future related to billing issues providers have reported in relation to reviewing the POC/worksheet.

5. We have had several members pass away, is someone somewhere getting these slots.

Answer: Per the Centers for Medicare & Medicaid, slots must be unduplicated in a fiscal year. Example: If a member has a slot and they only get one service before going off the program for whatever reason – that slot is gone until the next fiscal year.

6. Is there any chance of new members being opened under the Managed Enrollment?

Answer: If additional funding is allocated for the program.

7. In the past 2 years, there have been some slots opened for Waiver. Have these all been filled?

Answer: Most of them have been filled. There are still a few from the last slots that were released that are completing their financial eligibility.

8. Can you address why there are funds for Money Follows the Person which allows nursing home patients an opportunity to come home but decreases the amount of funding for Waiver which keeps people out of the nursing home in the first place?

Answer: Money Follows the Person is a federal grant with the Centers for Medicare & Medicaid. Money Follows the Person does not decrease funding for the Waiver.

9. According to policy, a felony offense prohibits a homemaker from working (in the caregiving field) if the offense was within the last 10 years. Policy also dictates that a homemaker cannot work at all (in the caregiving) field if there is a CPS/APS substantiation of maltreatment. This seems inequitable. Why should a homemaker be punished forever for an offense that carries no legal penalty but be excused after 10 years for a legal offense of the highest level?

Answer: The only offenses listed in Medicaid policy that has the 10 year limitation is felony DUI and felony drug related offenses. There is a process for individuals to apply to DHHR to request findings be removed from their DHHR Protective Services Record Check. Information on how to do this was sent out via email last week to all providers.

10. Is the Transportation Toolkit a policy, can we be cited for not following it? Or is it a guideline that the provider may use to increase efficiency and accuracy of services?

Answer: No, it is not policy. It is a guideline that provides best practices. However, there are some items in the Toolkit that refer to actual policies from the Aged & Disabled Waiver manual. Those specific were pointed out on the Transportation Toolkit Webinar held on 3/11/14. That webinar will be available in the near future on the WV Learning Center.

11. If the PAS says an individual is a LOC B, but after the CM and RN do the Member Assessment, they feel they don't even have 5 deficits, do we continue to provide services because they have been determined eligible by the WVMI PAS – or do we terminate services?

Answer: You cannot just terminate services because you think the PAS is incorrect and your assessment is correct. There are a multitude of things you can do in this situation. First, you should discuss this issue with the member. The member, if they no longer need services, can request a closure. Or if the member is not accepting the planned services, then you can request a closure due to noncompliance with the Plan of Care. If you consider it a fraudulent situation, you should complete a report with recipient fraud (304-558-1970). You can also contact the Bureau of Senior Services for technical support. And a new PAS can be completed with the provider present to assist in providing accurate and truthful information to WVMI.

12. If the PAS has determined a person is a LOC C, but after the CM and RN do the Member Assessment, it is determined that they only need LOC B services, do we give LOC C hours based on the PAS determination, or do we do LOC B hours based on our determination?

Answer: They should only be giving the person the hours they actually need regardless of LOC.

13. If we have a member who uses our transit services and needs the personal assistant/homemaker to go with the member to her non-emergency medical appointment in order to help with ambulation, toileting, transferring, etc., can we bill for the personal assistance/homemaker time? And can the Senior Center bill under transit for the mileage for non-emergency medical transportation?

Answer: Yes, you can bill for the personal assistance/homemaker time at medical appointments. Refer to DHHR for information/policy on NEMT services.

April 15, 2014

14. What is the policy on soliciting? Ex: Door to door soliciting and family/friend referrals where they give the provider an address to follow up with their family member.

Answer: There is no Medicaid policy on soliciting. Agencies can market their services in any legal manner they choose. Any harassment or intimidation of members is unacceptable and should be reported to the Bureau of Senior Services.

15. Is it ok if a member puts an "X" instead of initialing on the Plan of Care/worksheet?

Answer: Yes, they can make their own mark, but only if the member is incapable of signing their initials. If that is the case, it must be clinically documented as to why. This does not apply to every member and should only be for cases where their disability prevents them from initialing/signing

16. Is it true that if a member who is on the Managed Enrollment list is on an organ donor waiting list, that they will be moved to the top of the list? Is it also true that their spouse can work for them?

Answer: The answer is no to both questions.

17. Can a Medical Power of Attorney sign the POC/worksheet?

Answer: Only if the Medical Power of Attorney is in effect. A Medical Power of Attorney goes into effect when a person has been deemed incapacitated.

18. Does it matter who signs the paperwork if the member has Alzheimer's? Sometimes the member does but mostly it is the Medical Power of Attorney.

Answer: The member should sign if they are able. If there is a day they are unable due to disorientation, etc., then the Medical Power of Attorney can sign and it should be documented as to why.

19. What is policy if the Medical Power of Attorney is the homemaker and the Medical Power of Attorney also signs for the member?

Answer: Currently this is allowed in Traditional services but we highly recommend this is only used when there are no other options. This would require increased oversight to ensure services are being provided.

20. Why is it that per program policy, I can hire a twice convicted felon for drug related offenses occurring greater than 10 years ago but I must remove a direct care worker from providing services for a 13 year old DHHR Protective Services Record Check that amounted to nothing? Should the DHHR Record Check be amended to include allowed continued employment if the offense occurred greater than 10 years ago?

Answer: There is a process to have these removed from an individual's record if that is justified. Information regarding this process was emailed to providers on March 20, 2014.

21. Is the plan period on the Plan of Care to span a year or is it to span a 6 month period of time?

Answer: The plan period on the Plan of Care is to span a 6 month period of time. Ex. July, 2014 to December, 2014.

22. Regarding PAS extension requests made by Case Management agencies due to a PAS expiring before the re-evaluation can be conducted. Is the Bureau for Medical Services looking at WVMI and the need to reschedule appointments because their RN is unable to keep the appointment and the need to reschedule due to the member cancelling the appointment?

Answer: Yes. The reasons for all PAS's that are not conducted within 365 days are tracked and reported to the Bureau for Medical Services.

23. WVMI RN's get paid mileage to travel to Members homes, is this reimbursed by the State?

Answer: No.

24. Why do CM and HM/RN Agency's not get reimbursed for their mileage?

Answer: Transportation provides reimbursement for PA/HM direct care staff that performs essential errands for or with a member or community activities with a member. Transportation costs were considered when setting other reimbursement rates.

25. When are additional slots going to be released? What are the projected numbers to be served for your new fiscal year?

Answer: We are waiting on information regarding SFY15 budget and additional funding that could fund additional slots. The current ADW application with CMS has 5864 approved slots for SFY15. That would have to be amended with any additional funding/slots.

26. On the Plan of Care, do you need to put the day of the month? Or just the month and year?

Answer: The month and year.

27. Do you need to complete a RN Assessment (RN portion of the Member Assessment) after every hospital stay?

Answer: No, only if the members condition/needs change.

28. Regarding the 365 ADW slots released in August, 2013, how many have received their member enrollment as of today?

Answer: Most of them have been filled. This number changes day to day. This can be a lengthy process – we are currently contacting case management agencies about the importance of working diligently with individuals who select them as their case management agency to assist them in every way possible in getting their financial eligibility completed and getting them enrolled via the Bureau of Senior Services. If you have an individual who is not going to enroll due to not being financially eligible, no longer interested, etc. – you should immediately contact the Bureau of Senior Services (Barbara Paxton) at (304)558-3317 or Barbara.A.Paxton@wv.gov.

29. If we have a member who has MS and falls every day, do we have to do an incident report for each fall? (These falls do not involve injuries, the social worker is working on DME to assist with this matter. He likes to sweep his kitchen with a broom and falls out of his power chair – but does not want to stop trying to sweep).

Answer: If there is a fall with no injuries, you need to report each of these in the IMS system as a simple incident. A fall risk plan should also be developed and implemented for this member.

Updates:

1. An individual submitted a question regarding Chore services at Senior Centers. This question did not pertain to ADW services or Personal Care services. Senior Centers are allocated money that they can choose to use for chore services – but they are not required to. They can also use those funds for Lighthouse, FAIR, respite, meals, transportation, etc. Providers are prioritizing their funds for the services they feel are the most needed services.
2. Directors are no longer required to send a letter to Susan Given, Program Manager, Bureau for Medical Services for PAS extensions. An email was sent to providers regarding this on 4/1/14. As stated in the email, we ask that every effort be made to relay to members the importance of keeping the appointments that are made for them. We also ask that Case Managers refrain from asking members to cancel their appointments if they want to attend and have scheduling conflicts. There is no requirement for the Case Manager to be at the assessment. The best assistance in the re-evaluation process from a Case Manager is to ensure the MNER is completed appropriately.
3. We are currently beginning desk reviews for transportation services.

May 20, 2014

30. When a member is transferring both Case Management and Personal Assistance/Homemaker to the same agency, and the transfer date for each agency falls within two separate months such as the Personal Assistance/Homemaker transfer date is April 22 and the Case Management agency transfer date is 8 days later on May 1, can the Case Manager do the 6 month Service Plan in October instead of November so it can be done in the same month the RN is doing the Plan of Care?

Answer: Yes, it could be done in October. The key is to not go over the 6 month policy requirements. Ex. If you did it in December, you would be out of compliance with policy.

31. Why does the Personal Options give $1000.00 yearly allowance for the purchase of goods and services such as lift chairs and wheelchair ramps and the Traditional Option does not?

Answer: This is a service offered by the Centers for Medicare and Medicaid (CMS) that is only permitted in self-directed programs. The CMS service name even defines that as Personal Directed Goods and Services.

32. In the current manual on the change log page, it lists to replace section 501.3, Criminal Investigation Background checks; the change date says 4/25/12 with the effective date being 7/1/11. How can the change date be after the effective date? Also the manual notes at the bottom of every page effective date 9/1/11, should this not be 9/1/12? In the memo dated 4/28/14 from Susan Given Program Manager, it says ADW providers will not be required to submit DHHR Protective Services Records Checks for any employee hired prior to 9/1/11, should this not be 9/1/12?

Answer: Regarding the first question about the change date of 4/25/12 for CIB's, you are correct that the change date is wrong, that is a typo. The effective date of the manual is 9/1/11. Please note, that Susan Given's memo also strongly encourages providers to continue to submit these forms and to consider the results.

33. Since each agency now establishes their own mileage cap, what is to prevent a member from transferring somewhere that allows more mileage? We had a member that was considering leaving us to get more hours with Personal Options.

Answer: Nothing can prevent a member from transferring to another agency. Members have a right to choose their health care providers. However, if there are allegations of fraud, please report the fraud and contact the Bureau of Senior Services. At the direction of Bureau for Medical Services, the Bureau of Senior Services will be doing desk audits on transportation.

34. Regarding discontinuation of services, the manual states that when no services have been provided for 180 continuous days, the discontinuation of services is required. I just want to get clarification that this includes the weekends, not just Monday through Friday?

Answer: Yes, it is counted by calendar days.

35. Are there restrictions on what type of community activities the member can do if their homemaker is also a family member?

Answer: If it is an activity that the family member would be going to anyway, then they shouldn't be billing for that. If you have specific cases that you have questions about, contact the Bureau of Senior Services for technical assistance.

36. When a person wants to apply for ADW services, why does the MNER portion of eligibility come before the financial eligibility?

Answer: Medical eligibility must be established before financial eligibility can be established.

37. If a person has gone through the whole process of medical eligibility, including submission of the MNER form and RN visit with WVMI, but ends up not financially qualified, is that person taking a slot on the Managed Enrollment List?

Answer: We aren't sure if this question was what the person who submitted it intended to ask. But to answer the question that was submitted, if a person is found medically eligible but is found not to be financially eligible, they are no longer on the Managed Enrollment List. But to also answer what we believe the question was intended to be, if a person is found medically eligible but is found not to be financially eligible, they are not taking an actual waiver slot on the program.

Program Updates:

We received a question regarding the Aging & Disability Resource Centers (ADRC's). For any questions regarding the ADRC's, please contact Jenni Sutherland at (304)558-3317 or Jenni.L.Sutherland@wv.gov

June 17, 2014

38. According to the Service Plan Addendum policy, if a member has a Service Level Change, a new Service Plan must be done. This is not in the manual. When did it become policy?

Answer: This no longer requires a new Service Plan (however you can do one if you choose to). If you choose not to do a new Service Plan, you would need to do a Service Plan Addendum.

39. Please explain the correct use of "B: on page 2 of the Service Plan. Does this look at 24 hours 7 days a week? Or just the time the PA/HM is scheduled?

Answer: Please refer to the Service Plan Instructions # 16 on the Bureau for Medical Services website at www.dhhr.wv.gov/bms The Service Plan does look at how member needs are being met 24/7. "B" indicates that the member is using both formal and informal support to meet one or more of their needs. There is an example as well on the instruction sheet.

40. I hear Case Management agencies and Homemaker agencies will be going to a new computerized system. When will this take effect? How will personnel be trained?

Answer: APS Healthcare's ADW CareConnection© is tentatively scheduled to go live during July 2014. Providers have registered their agencies and users for the system over the last year. To provide an introduction to the system, APS conducted an initial round of webinars in May, 2014, for Case Management agencies, Homemaker Agencies, and the fiscal/employer agent. An email with the schedule for monthly repeat sessions of the webinar has been sent to all providers. Prior to go live, an APS staff member will also be assigned to each provider agency to provide technical assistance and training on the system.

41. Some of my members do not have informal supports when a homemaker is not available or when an emergency arises. How do other Case Managers address this issue? What do they put on the Service Plan and what suggestions are made to the member?

Answer: Every member's situation is different and unique. Case Managers seek out resources in their members communities for informal support – such as neighbors, churches, universities, schools, etc. If a person is getting the maximum number of hours of services permitted on the program and their needs cannot be met within the parameters of this program and this in turn creates health & safety issues, alternatives may need to be considered such as assisted living, nursing home placement, etc.

July 15, 2014

42. How specific should the details be on the Plan of Care? For example, there is not enough room to list what help is needed with each piece of clothing under dressing. Also, is it o.k. to list examples on essential errands such as shopping 1-2 times per week instead of writing specific days to go grocery shopping?

Answer: There are many questions being asked. The most important thing to remember is the Plan of Care is the member's plan based on his/her needs and preferences as specified in the Service Plan. The Plan of Care should reflect those needs/preferences. To address the specific questions above – it is not required that the Plan of Care be specific to each piece of clothing under dressing. But if you feel for some reason that your direct care worker needs additional instructions for a particular member you should provide those detailed instructions which don't necessarily have to be on the Plan of Care. Regarding grocery shopping 1-2x per week. Grocery shopping should preferably be 1x per week. If a situation occurs that requires an additional grocery shopping trip in a specific week that can be documented and approved by the agency RN. You should be specific about the day of the week for essential errands. Remember this is a plan and it provides instruction/direction to your direct care worker on what tasks they are to be providing for Medicaid reimbursement and it should also be consistent with the Service Plan.

43. *Question asked during the conference call:* If we designate a specific day of the week for grocery shopping, Ex. Monday, and then they have to go to the doctor on that day so we need to change the grocery shopping to another day – do we just document that in the comment section?

Answer: Yes, the direct care worker and the RN must be in communication about any change that occurs, the RN must approve this change in the schedule and it must be documented in the comment section.

44. ***Question asked during the conference call:*** Can we put a specific day of the week for essential errands such as grocery shopping and then also put "or as needed"?
Answer: No, you cannot do this. The Plan of Care needs to be specific. Again, remember that this is a plan that provides instruction and direction to your direct care worker regarding specifically what they are to be doing for the member. If you put "or as needed" that essentially permits them to deviate from the member's Plan of Care at any given time and decide when/what they are going to do on any given day.

45. I recently attended a Service Plan meeting with a Case Manager from another agency. This member had transferred their HM services and the timeframes for when my HMA RN Assessment was due and their CM Assessment and Service Plan were due were not at the same time. The Case Manager stated I needed to complete my HMA Assessment at the same time as the Service Plan to "get them together". This would have been 3 months early for my HMA RN Assessment.

Answer: The Case Manager is incorrect. You do not have to complete the HMA Assessment at the same time as the Service Plan to "get them together". The 6 month and annual Service Plan meeting require both the Case Manager and HM RN attend. The most recent HM RN Assessment can be used at that Service Plan meeting. The HM RN can use the RN Member Contact form at that meeting to document the meeting, changes, etc. The HM RN's 6 month and annual HM RN Assessment may not ever match up with the Service Plan meeting.

46. If a RN while reviewing a HM worksheet finds incorrect travel information – ex., wrong mileage, travel time, whether it's an essential errand or a community activity, how do you want us to fix this? We've been crossing out the incorrect information and writing in the correct information.

Answer: You should not correct/change another employee's documentation. The personal assistant/homemaker should be correcting any mistakes they make – they can draw a line, correct and initial.

August 19, 2014

47. I understand that we are not to use PRN on our POCs. So, if we get a SP with PRN on it, do we use it so the POC matches the SP?

Answer: Yes, if the service is to be provided as needed, you can abbreviate by noting PRN but it can't stand alone. It must be complete with frequency and day of the week. Example: 1 x week PRN on Wednesday.

48. ***Can payment for tolls be turned for reimbursement under mileage?***

Answer: No.

49. The Homemaker calls in sick two (2) days in a week. The client would or would not receive a HM for those days, based on availability of a substitute. The client calls the next week and wants to "make-up" those hours by having the HM stay later. The client does not need the "make-up" hours for personal care, rather she wants the HM to clean her house and do other tasks for her that may or may not be identified on the POC. How do we address this with the client?

Answer: Services are provided based on the member needs and noted the POC. Once the service is missed it cannot be "made up".
Example: If the member missed a bath on Tuesday the PA/HM cannot "make up" the missed service by giving the member two baths on Wednesday.

50. In light of the CareConnection© Program;

1. Do we still need to submit transfer requests to BoSS? Yes
2. Do we still need to get closures authorized by BoSS? Yes
3. Do Case Management Agencies still have to do monthly reports? ***Yes***
4. Do we need to print out everything from CareConnection© for members chart? Yes

Answer: Yes to all four questions. All requests can be uploaded in CareConnection© , fax or mailed to BoSS. Documents can be printed from CareConnection© for the member record.

Announcement:

1. The question numbering was changed to assist in referencing duplicate questions.

2. The Service Plan and Plan of Care Webinar conducted on July 31st is now available on the On Line Learning Center at http://www.onlinelearning.wv.gov . A copy of the Power Point is on the BoSS web site at www.wvseniorservices@wv.gov.

3. When attaching PAS additional doc or other information into ADW CareConnection© system, neither APS, nor WVMI is not notified via the system. Please be sure to notify us by emailing ADWAdditionalInformation@WVMI.org. To efficiently process these emails, it would be most helpful if the sender minimally includes the APSID#, a summary of the document(s) attached and/or purpose for sending the information. There is no need to include clinical information or member identifying information, as we can retrieve from the CareConnection© system. This is group mailbox and will be monitored daily."